

**Neuropsychology of Northern Virginia™
at Psychological and Life Skills Associates**

13885 Hedgewood Drive, Suite 233, Woodbridge, VA 22193
601 Jefferson Davis Highway, Suite 101, Fredericksburg, VA 22401
2960 Chain Bridge Road, Suite 200, Oakton, VA 22124

Adult Intake Questionnaire for Evaluation

Referred by: _____
Name _____ Today's Date _____
Date of Birth _____ Place of Birth _____ Social Security Number _____
Home Address _____ City _____ Zip Code _____
Home Ph: _____ Cell Ph: _____ Work Ph: _____
Level of Education _____ Occupation _____
Employer _____
Marital Status: Married Single Divorced __ Widowed
Spouse Name _____ Spouse Phone _____
Email _____

Has a prior psychological/neuropsychological evaluation been completed before?
If yes, name of service provider: _____
Findings of evaluation: _____
Prior diagnosis: _____

Please describe your presenting problem, what questions would you like answered based on this evaluation: _____

Current Family Structure: (residing in the home)

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Job/School</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Children: (not in home)

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Job/School</u>
_____	_____	_____	_____
_____	_____	_____	_____

Family of Origin Structure: Include parent/caregivers, step-parents, medical/mental history (substance abuse, cancer, depression).

Parents		Marital	Job/	Medical/Mental
<u>Name</u>	<u>Relationship</u>	<u>Age Status</u>	<u>Occupation</u>	<u>History</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Client Name: _____

Siblings

<u>Name</u>	<u>Relationship</u>	<u>Marital Age Status</u>	<u>Job/ Occupation</u>	<u>Medical/Mental History</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Symptoms: Please check all that apply and are applicable:

General:

- Irritability
- Aggression
- High activity level
- Staring spells
- Trouble expressing him/herself
- Frequent fatigue
- Low energy level
- Trouble falling asleep
- Trouble getting up in the morning
- Frequent awakenings during the night
- Easily frustrated
- Recent weight gain/loss
- Recent changes in appetite
- Excessive fears/worries
- Social isolation
- Depressed mood
- Mood swings
- Hopelessness
- Anxiety
- Anger/rage
- Guilt
- Grief/mourning
- Past history of sexual abuse
- Past history of physical abuse
- Coping with pain
- Aches and pains
- Suicidal thoughts/actions
- Desire to hurt someone
- Drug/Alcohol use
- Tobacco use
- Self-Harm
- Problems in thinking
- Problems with memory
- Other: _____

Physical

- Headaches
- Dizziness
- Nausea
- Vomiting
- Urinary incontinence
- Loss of bowel control
- Fainting
- Other: _____

Sensory

- Loss of feelings/numbness
- Tingling/strange skin sensations
- Difficulty telling hot and cold
- Blurred vision/blank spots
- Brief periods of blindness
- Double vision
- Difficulty looking quickly from one object to another
- Difficulty hearing
- Difficulty tasting foods
- Difficulty smelling/strange odors
- Other: _____

Concentration

- Distractible
- Loses train of thought
- Other: _____

Memory

- Forgetting:
 - Where things are left
 - Names
 - What you were doing
 - Where you were going
 - Long term events
 - Needs hints and reminders
 - Other: _____

Activities of Daily Living

- Difficulty with:
 - Dressing
 - Bathing/showering
 - Requires help for toileting
 - Eating/feedings
 - Table manners
 - Meal preparation
 - Making purchases (dealing with money)
 - Driving
 - Other: _____

Motor and Coordination

- Fine motor control difficulties
- Weakness on one side of body
- Difficulty holding objects
- Shakiness/tics
- Changes in writing
- Balance problems
- Difficulty initiating movement
- Muscles tire quickly
- Other: _____

Nonverbal Skills

- Difficulty telling right from left
- Difficulty brushing teeth, etc.
- Getting lost in familiar places
- Difficulty recognizing objects/people
- Difficulty with puzzles, problems drawing
- Slow reaction time
- Difficulty recognizing facial expressions
- Other: _____

Speech/Language/Academic Skills

- Difficulty with:
 - Word finding/naming
 - Staying on topic
 - Understanding what others say
 - Reading phonetically
 - Comprehending reading, writing, spelling, math
 - Letters move on page, must use finger to track reading
 - Speech behind/slurred, unusual speech sounds
 - Other: _____

Problem Solving

- Difficulty with:
 - Figuring out how to complete new tasks
 - Planning/organizing
 - Quick thinking
 - Sequential tasks
 - Changing a plan/activity/transitioning
 - Completing tasks in time
 - Multitasking
 - Other: _____

Relevant Health and Mental Health History:

Physician Name _____ Physician Phone _____
Medical or mental health conditions _____
History of substance abuse problems _____

Medical/ Functioning Testing and Lab Work History:

Check all medical/functioning tests that have been recently completed and report any findings:

___ Blood Work ___ Auditory Processing ___ Developmental Vision
___ CT Scan ___ Occupational Therapy ___ Speech Therapy
___ EEG ___ MRI of Brain

Handedness:

___ Right ___ Left Handed

History of concussion/head injury or loss of consciousness: _____

History of academic difficulties/special education services: _____

Is vision and hearing intact? _____

Are glasses or hearing aid utilized? _____

Were all developmental milestones reached on time? _____

Frequency of use of the following: Alcohol _____ Caffeine _____ Nicotine _____

Other Substances (e.g., marijuana, cocaine, sleeping pills) _____

Previous hospitalizations and date(s) _____

Current Medications:

Medication

Dose

Treating Physician

History of Psychotherapy, Occupational Therapy, Speech Therapy, Physical Therapy, etc.:

Previous Therapist

Dates

Issues Addressed

Client Signature _____

Date _____

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Evaluation Consent Form

Nature and Purpose of Assessment: The goal of neuropsychological assessment is to determine if any changes have occurred in your attention, memory, language, problem solving, or other cognitive functions. A neuropsychological assessment may point to changes in brain function and suggest possible methods and treatments for rehabilitation. In addition to an interview where we will be asking you questions about your background and current medical symptoms we may be using different techniques and standardized tests including but not limited to asking questions about your knowledge of certain topics, reading, drawing figures and shapes, listening to recorded tapes, viewing printed material, and manipulating objects.

Foreseeable Risks, Discomforts, and Benefits: For some individual's assessments can cause fatigue, frustration, and anxiousness.

Limits of Confidentiality: Information obtained during assessments is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults; and c) issuance of a subpoena from a court of law.

What to Expect/Additional Information:

If you have been referred or believe that your child would benefit from a neuropsychological evaluation, call our front desk in order to schedule an appointment. Please complete the intake form and bring it to your first appointment. Be sure to bring with you to the first appointment any relevant medical records, school records (grades, IEP/504 plan, psychological evaluations, etc.) as well as any prior evaluations (occupational therapy, speech therapy, neuropsychological, developmental vision, etc.).

While the evaluations for children 6 and under can vary in length of time, those 6 and older can expect to obtain 8 hours of direct patient time (intake, testing, and feedback). This does not include the numerous "behind the scenes" hours which include reviewing relevant records (medical, school, etc.), developing an individualized testing battery, scoring, interpreting, and report writing. This is why a neuropsychological evaluation is an invaluable asset to your child's care.

Keep in mind that any relevant information that is provided during the evaluation process will be included in the written report, as deemed appropriate. Also, a diagnosis is not always warranted if the data does not support one. Intake paperwork should be brought completed to the first appointment. If you have not completed all paperwork, please arrive 45 minutes prior to your appointment and complete all in our waiting room.

Appointments:

Age group: 2 years and 6 months - 5 years and 11 months

1st appointment (Intake): Only the parents are asked to attend the clinical intake interview appointment (1h) as it tends to be difficult to discuss certain matters with younger children in the room. Upon the completion of this appointment, the testing and feedback appointments will be scheduled. Be sure to bring with you all paperwork mentioned earlier. Expect to go home with various screeners to complete and bring to the next appointment. 2nd appointment (Testing): This appointment can vary in length but will typically range from 1 to 3 hours. You may be asked to sit in with your child during some of the testing or you will be asked to remain in the waiting room. Do not leave the building while your child is testing.

3rd appointment (Feedback): Again, only the parents are asked to attend the feedback appointment (1h). This should take place approximately 3 weeks after testing is completed. At this time, the results of the evaluation will be discussed with the family.

Age group: 6 years old and up

1st appointment (Intake): The parents AND child are asked to attend the clinical intake interview appointment (1h) as the neuropsychologist will keep the child to begin testing (1h) upon the completion of the intake (2h total appointment time). Upon the completion of this appointment, the additional testing and feedback appointments will be scheduled. Be sure to bring with you all paperwork mentioned earlier. Expect to go home with various screeners to complete and bring to the next appointment.

2nd appointment (Testing): This appointment can vary in length but will typically involve 5 hours. A typical testing day includes testing 9am to 12pm, an hour lunch break where you and your child are welcome to leave the office, and testing 1pm to 3pm. You may be asked to sit in with your child during some of the testing but will likely be asked to remain in the waiting room. Do not leave the building while your child is testing unless they are of an approved age for you to do so.

3rd appointment (Feedback): Unless the child is 18 years old or of an age where they can comprehend and benefit from the discussion, only the parents are asked to attend the feedback appointment (1h). This should take place approximately 3 weeks after testing is completed. At this time, the results of the evaluation will be discussed with the family.

On rare occasions, testing may need to be split up into two testing days or additional hours of testing may be required. This will be discussed on a case by case basis as it applied to your child.

Please contact our front desk in order to discuss payment questions.

Evaluation Cost:

\$2,100 for ages 6 years and older-this includes a clinical intake, up to 6 hours of testing, feedback session, review of prior records, scoring, interpreting data, and report writing

\$1,575 for ages under 6 years-this includes a clinical intake, up to 3 hours of testing, feedback session, review of prior records, scoring, interpreting data, and report writing

If testing goes longer than the allotted amount of time, there will be an additional \$175 fee per extra hour of testing. We are understanding of financial restrictions and will work with families on a sliding scale fee as deemed necessary and if approved in advance.

While we do not directly deal with out of network insurance, once the evaluation is completed, you will be provided with the necessary information to submit to your insurance to attempt to obtain reimbursement yourself. Reimbursement by out of network insurance is not guaranteed on our end. Payment will be collected on three separate occasions (during intake, testing, and feedback appointments) and final amount will be adjusted as needed during the last feedback appointment. Keep in mind that the private pay process will allow you to receive services faster since insurance clearance for neuropsychological services may take up to several months. Due to the limited time of the neuropsychologist, attending any school meetings in person will be unlikely. However, phone/email consultations with the school can be scheduled on a case by case basis for an additional fee.

I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing.

Patient Signature

Date

Parent/Guardian or Authorized Surrogate (if applicable)

Date

Witness Signature

Date

REPORT RELEASE POLICY UPDATE

04/2017

Please note that while the clinician will meet with you to verbally discuss the findings of the evaluation approximately 3 weeks upon the completion of testing, we will release the actual report and mail it to you just as soon as all payment has been collected. This includes insurance reimbursement, copays, private pay, or payment covered by the school system.

I have read and agree with the above statement. I have had an opportunity to clarify any questions and discuss any points of concern before signing.

Patient Signature

Date

Parent/Guardian or Authorized Surrogate

Date

Witness Signature

Date

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NOTICE OF OUR PRIVACY PRACTICES

UNDERSTANDING YOUR HEALTH RECORD & INFORMATION: Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS: Unless otherwise required by law your health record is the physical property of Neuropsychology of Northern Virginia™. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your mental health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your mental health record. You may obtain an accounting of disclosures of your mental health information, request communications of your mental health information by alternative means or at alternative locations, revoke your authorization to use or disclose mental health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES: The Neuropsychology of Northern Virginia™ is required to maintain the privacy of your mental health information, and in addition, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected mental health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided. We will not use or disclose your mental health information without your authorization, except as described in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We will use your mental health information for treatment: Information obtained by your therapist will be recorded in your record and used to determine the course of treatment that should work best for you.

We will use your mental health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, relevant history, and treatment given.

Law enforcement: We may disclose mental health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your mental health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public. We will attempt to contact you first to see if you consent to such release.

Child Abuse: If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services. We will discuss this with you as appropriate.

Abuse of Elderly or Incapacitated Adults: When we have reason to suspect that an incapacitated adult (e.g. someone who is not able to advocate for himself or herself) is being abused, neglected or exploited, we are required by law to make a report and provide relevant information to the Virginia Department of Social Services. You will be notified of this action unless your therapist believes that it would put you at risk of serious harm.

Health Oversight: The Virginia Board of Health Professions, including the Boards of Psychology, Social Work, and Counseling, has the power to subpoena relevant records should we be the focus of an inquiry.

Judicial or Administrative Proceedings (Court Orders): If you are involved in a court proceeding and a request is made for information about your treatment, we will not release information without your written authorization. If we receive a Subpoena for your records (of which you have been served, along with the proper notice required by state law) we are required to respond. We will attempt to contact you first to see if you consent to such release. If you object, you may file a motion, with the clerk of the court to move to quash (block) the subpoena. If you pursue this, notify your therapist as soon as possible. We are then required to place your records in a sealed envelope and provide them to the clerk of the court so that the court can determine whether the records should be released.

Serious Threat to Health or Safety of Others: If you communicate to us a specific and immediate threat to cause serious bodily injury or death to an identified or to a readily identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we must take steps to protect the threatened person.

Danger to Self: Your therapist can break confidentiality if you (or your child) are in imminent danger of hurting yourself, in order to keep you (or your child) safe. This may include notifying emergency personnel.

Worker's Compensation: If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant PHI to you, your employer, the insurer, or a certified rehabilitation provider.

Debt Collection: Your name can be reported to a collection agency and/or a credit bureau if you fail to pay your bill. You will be notified before such a report is made.

Legal Defense: Disclosure may be made if a therapist must arrange for legal consultation if a patient takes legal action against a therapist.

Effective Date: This notice will be effective on April 14, 2003

Modification & Amendment: This notice may be modified or amended by other documents, upon notification from your healthcare provider.

To obtain more information, or if you have any questions about this form, please contact our privacy officer:

*Dr. Christopher T. Haley
13885 Hedgewood Drive #245
Woodbridge, VA 22193
(703)490-0336*

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Our Financial Policy

Welcome to the office of Neuropsychology of Northern Virginia™. In order to ensure the efficiency of our practice, we wish to explain our policy with regard to financial responsibility for sessions with the psychotherapists from this office.

All payments are due prior to each session. We do participate with a limited number of insurance carriers. You are responsible for any costs that your insurance does not cover.

While we do not directly deal with out of network insurance, once the evaluation is completed, you will be provided with the necessary information to submit to your insurance to attempt to obtain reimbursement yourself. Reimbursement by out of network insurance is not guaranteed on our end. Payment will be collected on three separate occasions (during intake, testing, and feedback appointments) and final amount will be adjusted as needed during the last feedback appointment. Keep in mind that the private pay process will allow you to receive services faster since insurance clearance for neuropsychological services may take up to several months. Due to the limited time of the neuropsychologist, attending any school meetings in person will be unlikely. However, phone/ email consultations with the school can be scheduled on a case by case basis for an additional fee.

Our Late Cancellation/No-Show Policy

If you are unable to keep a scheduled appointment, you are required to give us at least a 24- hour notice. Late cancellations (with less than 24 hours' notice) and No Shows (missing a scheduled appointment) are charged \$75 per hour of appointment, regardless of the reason. This fee cannot be billed to insurance.

Statement Fee

All payments are due at the time of service. If a balance is owed and a statement is mailed to you, you will be charged a \$5.00 statement fee for each statement sent to you.

Collections Services

We are contracted with collection services to recover any money owed to Neuropsychology of Northern Virginia™.

Returned Checks

The return of a check (electronic or paper) issued to Neuropsychology of Northern Virginia™ will result in a \$25.00 returned check fee being placed on the account of the patient, or individual, on whose behalf the check was presented for each returned check, no matter the reason.

The undersigned has read, understands, and agrees to the above terms and conditions.

Signature of Person Financially Responsible

Date

Address (if other than patient's)

Signature of Therapist/Witness

Date of birth of financially responsible party

**All Payments Are Due at the Time of Your Appointment
And You Must Agree to One of the Following (please initialone):**

Initial here

I agree to pay my session fee/co-pay in full at the time of service using one of the methods below.

1. **BY CASH:** We will gladly accept cash payments and will provide you with a receipt of payment.
2. **BY CREDIT:** We accept all major carriers.
3. **BY CHECK:** Please make checks payable to **Neuropsychology of Northern Virginia™**. You may give the check to your therapist or the office staff.

Initial here

I request that my credit or debit card be charged for each session at the time of service. (please complete below)

NAME OF CLIENT _____
Card # _____
Exp date _____
Sec code _____
Billing zip _____
Name of Cardholder _____
Signature _____
Address (if different than above) _____

Insurance Information

Ins. Co. (Name/Addr): _____

Policy Holders Name: _____ DOB: _____ SSN and Insurance ID: _____

If Military (Active/Retired): _____

Any secondary insurance?(if so, name of company) _____

Policy Holders Name (if different from above): _____ DOB: _____

SSN and Insurance ID: _____

NOTE: Tricare Options Standard please alert your therapist if you have used any of your mental health benefits since October 1.

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Consent for Nonsecure Communications

We will use reasonable means to protect the security and confidentiality of email information sent and received. However, because the nonsecure nature of these communications, we cannot guarantee the security or privacy and are not liable for improper disclosure of confidential information that is not caused by our intentional misuse.

The use of unencrypted email can be a convenient and fast way to communicate between a client and provider. As a client, you have the right to use this form of communication.

The types of information that are most often communicated via e-mail include: appointment scheduling, transmission of blank office forms or paperwork, referral information and answering basic questions. It is preferred to discuss private matters in session and not through electronic communication.

Transmitting client information by e-mail has a number of risks that clients should consider before using e-mail to communicate with your provider. These include, but are not limited to, the following risks:

RISKS OF USING EMAIL COMMUNICATION

- Can be circulated, forwarded and stored in numerous paper and electronic files.
- Can be immediately broadcast worldwide and be received by unintended recipients.
- Senders can easily type in the wrong email address.
- Is easier to falsify than handwritten or signed documents.
- Backup copies may exist even after the sender or the recipient has deleted his or her copy.
- Employers and online services have a right to archive and inspect e-mails transmitted through their systems.
- Can be intercepted, altered, forwarded, or used without authorization or detection.
- Can be used to introduce viruses into computer systems.
- Can be used as evidence in court.

CLIENT OBLIGATIONS WHEN CONSENTING TO E-MAIL COMMUNICATION

- Use e-mail for general client information only. Do not use for medical emergencies, other time sensitive matters, or for non-general medical information.
- Follow-up with provider if you have not received a response within 5 business days.
- Take precautions to preserve confidentiality. Use screen savers and safeguard your computer password.
- Inform your provider of any changes to your e-mail address.
- Withdraw consent to email client information through hardcopy written communication to your provider.
- I understand that I may also communicate with my provider via telephone or during a scheduled appointment and that e-mail is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive information.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I **do not** grant permission to be contact by email even when initiated by me.

OR

I agree to the following non-secure communication with my provider:

Email

Client Signature

Printed Name

Date

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**Consent for Release and Use of Confidential Information
And
Acknowledgement of Notice of Privacy Practices**

I, _____ hereby
(Name of Patient or Authorized Agent)
give my consent to Neuropsychology of Northern Virginia™ to use or disclose, for the
purpose of carrying out treatment, payment, or health care operations, all information
contained in the patient record of: _____.

I acknowledge the review and/or receipt of the Notice of Privacy Practices.
The Notice of Privacy Practice provides detailed information about how the practice
may use and disclose my confidential information.

I understand that my therapist has reserved a right to change his or her
privacy practices that are described in the Notice. I also understand that a copy of
any Revised Notice will be available to me upon a written request to the Privacy
Officer.

I understand that this consent is valid until it is revoked by me. I understand
that I may revoke this consent at any time by giving written notice of my desire to
do so, to my therapist. I also understand that I will not be able to revoke this
consent in cases where the therapist has already relied on it to use or disclose my
mental health information. Written revocation of consent must be sent to our office.

I understand that I have the right to request that the practice restricts how
my individually identifiable mental health information is used and/or disclosed to
carry out treatment, payment or health operations. I understand that the practice
does not have to agree to such restrictions, but that once such restrictions are agreed
to, the practice and their agents must adhere to such restrictions.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

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Charges for Ancillary Services

Please be aware that it is our policy to charge for non-clinical services. Such services include, but are not limited to, telephone consultations with other providers or schools, writing letters on behalf of clients, completing paperwork at the request of clients (e.g. filling out disability paperwork), and fielding emergency calls. Charges will reflect the time needed to complete the service and is billed in 15 minute increments at a rate of \$250/hour.

***Please note that advance notification will be sent before additional charges are applied.**

For example:

15 minutes = \$62.50

30 minutes = \$125.00

45 minutes = \$187.50

60 minutes = \$250.00

Charges for Medical Records

Searching and Handling Fee: \$10

Pages 1-50: \$0.50 per page

Pages 51 +: \$0.25 per page

I have read, understand, and agree to the above office policy.

Signature of Patient

Date